

MEDICATION AUTHORIZATION FOR PRESCRIPTION and OVER-THE-COUNTER MEDICATIONS

AUTHORIZATION FOR MEDICATION TO BE TAKEN DURING SCHOOL HOURS. Educational Code 49423 and 49423.5. Any pupil who is required to take prescribed medication by a physician may be assisted by the school nurse or other designated school personnel if the school receives (1) a written statement from such physician detailing the method, amount, and time schedules by which such medication is to be taken and (2) a written statement from the parent or guardian of the pupil indicating the desire that the school assist the pupil in the matters set forth in the physician’s statement. **CAC Title 5, 18170.**

HAVE PHARMACY OR PHYSICIAN PROPERLY LABEL MEDICATION IN A SEALED CONTAINER FOR SCHOOL ADMINISTRATION.

Required - to be completed by parent or guardian:

I request that designated personnel assist my child in taking the medication prescribed by a physician. I understand that my child **may not** have or take medication at school unless **all** requirements are met. I also request that my child be assisted in taking over-the-counter medications. The type of medication will be determined by the symptoms presented by the student. I hereby give consent for the school nurse to communicate with my physician as needed with regard to these medications. The prescribing physician **must** provide the Health Office with written documentation whenever your student begins taking a new medication, discontinues a medication, or changes the dosage of a current medication.

All medications must be distributed through the Health Office. No medication (prescription or over-the-counter) may be kept by the student in their room. Exceptions are asthma medication, some dermatological creams, vitamins, supplements, and herbal supplements. However, these must be presented to the Nurse and will be labeled and returned to the student. Any unauthorized items found in the student’s room could lead to disciplinary action. If mailing, please address all medications, vitamins, supplements, etc, to the attention of the Health Office, *not your student.*

Student’s Name _____ Sex _____ Birthdate _____

Allergies to Medications _____

Physician’s Name _____

Parent/Guardian Signature _____ Date _____